STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001128	A. BUILDING: _____ B. WING _____	04/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS FELLOWSHIP COMMUNITY	2030 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	INITIAL COMMENTS This visit was for a State Licensure Survey. Survey dates: April 3, 4 and 5, 2013 Facility number: 001128 Provider number: 001128 AIM number: NA Survey team: Sharon Lasher RN, TC Barbara Gray RN Leslie Parrett RN Angel Tomlinson RN Census bed type: NCC: 65 Residential: 122 Total: 187 Census payor type: NCC: 65 Residential: 122 Total: 187 Sample: 15 Friends Fellowship was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey. Quality Review 04/08/13 by Lisa McColly	F 000		